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	SECTION A - Child Care Services are
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	equested by or on behalf of Applic
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	Applicant
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	plicant (Head of Famil)
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ARE SERVICI		of applicant (ast nam	e, first name, mid	dle initial)								
	2. Addre	ss (number ar	nd street	,e	'IP code)								
	3. Single ☐ Yes [) parent? □No □N/A	4. Cour			ool distri	ct number	5. Tel	ephone	numbei)	7		
urself and ALL FAMILY definition of family on Ir	eet.)	5. Relationship	6.	7. Recipient	8.	9.	10. Ethnic	<u>⊆</u>	cle Y o	1. Race r N in E	ACH bo		12. Adult
2. 3. te of Birth Citizen	4. Custodial adult?	to applicant	Gender	Indentification Number	Hoosier Healthwise?	TANE?	or Latino?	_	2	3	4	5 0 - 9	Need Code+
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eceived (<i>in the last</i> od TANF) need not l	<i>30 days</i>) by fami be reported.	ly members liv	ing in yo	ur household.	**RACIAL /	ETHNI tion B.1	C CODE	I	+SERV	Sect. B.	ED COI 12)	. H	
2. Mont for Eli	hly Gross Incor gibility Purpose		(see co	de(s)	Alaskan N 2. Asian	lindian , Vative			ining / E	ducation 2	n Ine Job	I raillin	۷
					3. Black or A 4. Native Ha other Pac 5. White 6. Multiracia	Atrican / awaiian / sific Islar	American I Ider	4. Chi 5. Oth Exp	ld Prote er (<i>new</i> lain:	ction Se job, job	rvices search		
							++Inco	me So Section	urce Co	odes			
					1. Wages/E 2. TANF	mploym	ent						
					3. Other Sta 4. Housing	ate fundi voucher	ng / Cash ass	istance					
					5. Food Sta 6. SSI or oth	mps າer Fed	eral cash pi	rogram					
					7. Pension 8 Unemplo	vment							
t in family 7. Total f	amily income	8. Pover	y level		9. Child Sup	port							
otional. Your SSN i	is not required for State will keep	or child care e	ligibility onfident	and eligibility	11. Other (r	not coun	ted in eligik	oility)					
not identify indivi e child care pro	iduals; verify en gram; and / or	nployment an · match agai	d / or in nst TAI	icome; supply NF database.	DO NOT Co	DUNT #	3, #4, #5, ility	⊣	OTALS				
	ate of Birth Citizen Treceived (in the last of TANF) need not 1 # in family 7. Total for Eliptional. Your SSN in tidentify indiversity i	APPLICATION FOR CHILD CARE SERVICES State Form 45513 (R4 / 11-08) / BCD 0805 SECTION B - Family Members - Complete ALL information, (See definition of family on Instruction Sheet.) Interest Name First Name First Name First Name M.I. Date of Birth Chizan? Y / N	ARE SERVICES 1. Name of applicant () 2. Address (number ar as a contidentity on Instruction Sheet.) 2. Address (number ar as a contidentity on Instruction Sheet.) 2. A. Gustodial adult? 2. A. Gustodial adult? 2. A. Gustodial to applicant to applicant adult? 4. V / N	ARE SERVICES 1. Name of applicant (last nam of applicant) 2. Address (number and street) 2. Address (number and street) 2. Address (number and street) 3. Single parent? 4. Courber and Sheet. 4. Courber and Sheet. 6. Relationship 8. Relationship 9/N Y/N Y/N Relationship 9/N Y/N Y/N SELF M/F 9/N Y/N Y/N SELF M/F 9/N Y/N Y/N M/F 9/N Y/N W/N M/F 9/N Y/N M/F 9/N Y/N M/F 9/N Y/N SELF M/F 9/N Y/N M/F 9/N Y/N SELF M/F 9/N F 9/	Address (number and street, city, state, and z Single parent?	Address (number and street, city, state, and ZI Single parent? Yes \(\subseteq \text{No} \subseteq \text{N/A} \) Relationship to applicant Gender Indentification Household. SELF M / F SELF M / F M / F M / F M / F M / F SELF SELF M / F SELF M / F M / F SELF M / F SELF M / F M / F SELF SELF M / F SELF M / F SELF M / F M / F SELF SELF M / F SELF M / F SELF SELF M / F M / F SELF SELF M / F SELF M / F SELF SELF M / F SELF M / F SELF SELF M / F M / F SELF SELF M / F SELF SELF SELF SELF SELF SELF SELF SELF	Address (number and street, city, state, and ZI Single parent? Yes \(\subseteq \text{No} \subseteq \text{N/A} \) Relationship to applicant Gender Indentification Household. SELF M / F SELF M / F M / F M / F M / F M / F SELF SELF M / F SELF M / F M / F SELF M / F SELF M / F M / F SELF SELF M / F SELF M / F SELF M / F M / F SELF SELF M / F SELF M / F SELF SELF M / F M / F SELF SELF M / F SELF M / F SELF SELF M / F SELF M / F SELF SELF M / F M / F SELF SELF M / F SELF SELF SELF SELF SELF SELF SELF SELF	Name of applicant (last name, first name, middle initial) Address (number and street, city, state, and ZIP code) Single parent? Relationship of residence number Relationship of residence number Relationship of residence number Relationship of residence number 7. 8. 7. 8. 7. 8. 9. His Hoosier Hoosier Number	Name of applicant (last name, first name, middle initial) Address (number and street, city, state, and ZIP code) Yes No	Name of applicant (last name, first name, middle initial) Address (number and street, city, state, and ZIP code) Yes No	Name of applicant (last name, first name, middle initial) Address (number and street, city, state, and ZIP code) Yes No	Name of applicant (last name, first name, middle initial) Address (number and street, city, state, and ZIP code) Yes \[No \[NNA \] Relationship 6. Recipient Number School district number	Name of applicant (lest name, Inist name, middle inities) Satisfact number School district

٥	☐ Subsidy Information		☐ Mass Media Info Sites	☐ Legal Child Care Information	□ Legal Chil	Regulatory Information	Regulatory
nation	☐ Health/Safety Information	/ Policies	☐ Complaint Process / Pol	☐ Brochures on Quality Child Care	☐ Brochures	and Referral	☐ Resource and Referral
						SECTION F - Other Services Referred To	SECTION F - (
		5)	Re-determination date (month, day, year)	Re-		Eligibility determination date (month, day, year)	Eligibility deter
		Name of agency	Date child care subsidy ends	Date child care subsidy begins Date	Date child care	Original date of application (<i>month, day, year</i>)	Original date o
Date (month, day, year)		Signature of agency	or TANF referral date (<i>month, day, year</i>)		Date (month, day, year)	pplicant	Signature of applicant
offered a repayment	nounts and I will be o	repay the State such am	that if I receive CCDF benefits to which I am <u>not</u> entitled, for whatever reason, I shall be required to repay the State such amounts and I will be offered a repayment agreement by the State with a monthly payment option.	l am <u>not</u> entitled, for whate payment option.	nefits to which with a monthly p	that if I receive CCDF benefits to which I am <u>not</u> entitled agreement by the State with a monthly payment option	
			₃ time of application.	my Rights and Obligations and have received a copy of them at the time of application.	s and have rec	my Rights and Obligations	
			voided.	that if I fail to use my child care assistance within 60 days, it will be voided	d care assistan	that if I fail to use my child	
		assistance.	that failure to pay any child care co-pay could result in my family being terminated from this funding assistance	could result in my family be	ld care co-pay	that failure to pay any chil	
under 6 years of age.	care for my children	ts if I cannot obtain child	that as a custodial, single TANF client, I will not receive penalties associated with work requirements if I cannot obtain child care for my children under 6 years of age.	l will not receive penalties a	TANF client, I	that as a custodial, single	
			sed on a waiting list.	that this program is not an entitlement and, therefore, I may be placed on a waiting list.	า entitlement a	that this program is not ar	
			he public.	that the information I have given is private and cannot be seen by the public	e given is priva	that the information I have	
			₃ndar days.	that I must report changes to the voucher agent within ten (10) calendar days	s to the vouche	that I must report changes	
ion, sex, age, political	national origin, relig	y because of color, race,	that I have the right to treatment that is fair and does not discriminate. I will not be treated differently because of color, race, national origin, religion, sex, age, political beliefs, marital status, or because of a physical, mental, or emotional condition.	that I have the right to treatment that is fair and does not discriminate. I will not beliefs, marital status, or because of a physical, mental, or emotional condition.	atment that is t because of a p	that I have the right to treated beliefs, marital status, or t	
ssary contacts to verify	s, to make any neces	I am requesting services	that I may be requested to verify these statements and give my consent to the agency, from where I am requesting services, to make any necessary contacts to verify any statements.	statements and give my cor	ວ verify these ເ	that I may be requested to any statements.	
		of my knowledge.	and hereby certify that all the above information, provided by me, is true and correct to the best of n	ກrmation, provided by me, is	the above info		l understand: ——
						Signature	SECTION E - Signature
□Yes □No							
□Yes □No							
□Yes □No							
□Yes □No							
□Yes □No							
6. Receiving preschool services through child care program?	5. End date (month, day, year)	4. Start date (month, day, year)	3. Highest degree attained	2. Highest grade completed		1. Name (last, first, M.l.)	
		/ preschool	attending school / education / pre	begin/end dates for all those	bers including	SECTION D - Education level of all adult members including begin/end dates for all those attending school / education	SECTION D - I

Complete this page for the Provider Information. WHEN CHANGING PROVIDERS, only this page will need to be completed.

Signature of provider	I affirm that the information given in Sections	*FAMILY CO-PAY Based on Poverty Level. Use scale to determine.	γ,	/ Y	/ ۲	/ Y	/ Y	Y / N	2. 1. Proof of Special Needs?	SECTION H - Child Care Needs / Expenses for Family Name	7. Legally-exempt center-based care 8. Registered Ministry	Legally-exempt family care / non-relative Legally-exempt family care / relative	Legally-exempt in-home care / non-relative Legally-exempt in-home care / relative	#1. Licensed / Regulated family care #	9. Type of Care		5. Address (number and street required; PO Box is optional)		1. Name	SECTION G - Care Giver Information (Complete this section for each provider. Attach additional sheets if necessary.)
	ections G	**CHILD CARE SUBSIDY PER WEEK Calculate the following: #6 (Charge) minus #8 (Over Rate) #6 SPECIAL NEEDS, include appi	/ N	Z	Z	Z	Z	Z		mily Name _		elative	-relative tive	care			optional)			his section f
Date		SUBSIDY Pe e following: minus #8 (. NEEDS, in							3. Additional Cost for Special Needs		Number of sites	Capacity_	Date for renewal	License / R	10					or each pro
Date (month, day, year)	of this ap	ER WEEK Over Rate) clude appr							4. Total Hrs. of Care per Week		f sites		newal	egistration r). If License		6. City	\smile	2. Telepho	ovider. Att
y, year)	plication	minus #9 (opriate and							5. Service Need Hrs Days					าumber (<i>mu</i> ะ	10. If Licensed / Registered		ity		2. Telephone number	ach additic
	and H of this application is true and correct.	IILD CARE SUBSIDY PER WEEK Calculate the following: #6 (Charge) minus #8 (Over Rate) minus #9 (Co-Pay) equals #10 (Subsidy) IF SPECIAL NEEDS, include appropriate and approved additional costs.							6. Charges per Hr Day					License / Registration number (<i>must provide copy</i>)	red	, Z				nal sheets if
SD	d correc	ls #10 (Sut litional cos							Wk Hr	_ Appli		Relatio	Age	Date of birth	11.				3. Socia	necessary
Date to meet minimum standards (month, day, year)	ct.								7. Market Rate per	Application Date		Relationship to child		f birth	11. If Legally License-exempt Home		7. ZIF		3. Social Security / Employer ID number	2
t minimum ; year)		***FUND SOURCE CODES:							T	(e)		nild			cense-exe		7. ZIP code		Employer	
n standard:		JURCE CO							8. Over Rate Charge per Day Wk						mpt Home				ID numbe	
o,									9. Family Co-Pay* Day Week										Г	
Date fo		 Child Care and Developme CCDF - School Age Care Social Service Block Grant State School Age Care Preschool Pilot Project 							ek										4.	
Date for provider re-certification (month, day, year)		and Devel hool Age (vice Block of ol Age Car							10. Child Care Subsidy** (6 - 8 - 9 = 10) Hr Day Wk						12. Notes		8. County		4. Doing Business As	
re-certific		lopment F Sare Grant re													es		ŧγ		siness As	
ation		 Child Care and Development Fund (CCDF) CCDF - School Age Care Social Service Block Grant State School Age Care Preschool Pilot Project 							11. Fund Source *** (see codes below)											

Application For Child Care Services: Bureau of Child Development Instructions for completing SF 46513 / BCD 0805

NOTE: All information on this form is required for Federal or State reporting requirements. ALL information MUST be collected prior to determining eligibility: including Social Security Numbers for applicant(s) and children.

For the purposes of this program **FAMILY** is defined as: One or more adults and children, related by blood or law, residing in the same household. Where adults other than spouses reside together, each is considered a separate family. Wards of the Local Office of Family and Children are the legal responsibility of the local Office of the Division of Family and Children and not the family with which the child has been placed.

COMPLETE ALL UNSHADED AREAS / SHADED AREAS WILL BE COMPLETED BY THE VOUCHER AGENT:

Section A: Applicant Information

- 1. Full name of applicant (head of family)
- 2. Full mailing / physical address of applicant
- 3. Circle if the applicant is legally single. NA is appropriate only for children who are wards of the court through the Office of Family and Children.
- 4. Name / county ID number of the applicants resident county and School District Number.
- 5. Phone of applicant or contact phone number.

Section B: Applicant Family Information

- 1. Include names for all FAMILY members living in the household.
- 2. List date of birth for all family members.
- 3. Y if a US citizen and N if not a US citizen
- 4. Y if adult family member is a custodial parent and N if not.
- 5. List relationship to applicant (son / daughter / boyfriend / grandchild, etc.)
- 6. Gender Code only. 1 for Male / 2 for Female
- 7. Recipient Identification number is mandatory to be eligible for child care assistance.
- 8. Indicate if each family member is a Medicaid or Hoosier Healthwise participant with a Y or N.
- 9. Indicate if family member is a TANF recipient or not by Y or N.
- 10. Indicate, by using Y or N, if each family member is of Hispanic or Latino ethnic background.
- 11. Find the Race Code number at bottom of page. Each column MUST have a Y / N for each race indicator.
- 12. Use the Service Need Code number at the bottom of page to indicate service need OF THE ADULT FAMILY MEMBERS.

Section C: Family Income / Size Information

- 1. Include the name of each person receiving income/
- 2. Total gross monthly amount for income received in the previous 30 days. Use the INCOME SOURCE info at the bottom of page to total all income. Income of children under 16 yrs. is not counted, except TANF and SSI. Income reported in # 3,4,5 and 11 are reported, and can be declared by applicant, however is NOT used in determining eligibility. NO income is counted for Service Need #4: Child Protection Services.
- 3. List all Income Source Codes for each individual.
- 4. Total number of adults in family.
- 5. Total number of children in family.
- 6. Total number in family.
- 7. Total family income.
- 8. Poverty level of family based on scale.

Service Codes: Use these boxes / codes to complete the family information. In determining income be sure to subtract income from lines 3, 4, 5, and 11 before determining eligibility. Income on these lines may be declared by the appliant, available documentation should be included in the family file.

Section D: Education

To be completed for each family member as follows:

- 1. Name of family member.
- 2. Highest grade level completed by each adult family member.
- 3. Highest degree attained by each adult family member.
- 4. Start date of school for current year, if applicable.
- 5. End date of school for current year, if applicable.
- 6. Indicate with a Y or N if a preschool age child is receiving Preschool Services through the child care provider site.

Section E: Signatures: space has been provided along each statement for parent to initial upon reading statement.

Applicant MUST read or have read these statements, sign and date form prior to determining eligibility.

Agency person MUST sign and date

Original Date of Application: The date the family first came in and applied for assistance. This date will remain the same .

The duration of the family receiving assistance UNLESS there is a greater than 3 month break in service.

Date of Eligibility: Date family is determined eligible by Voucher Agent.

Date Child Care Subsidy Begins: First service need date that will be covered through funding.

Date Child Care Subsidy Ends: Last date of eligibility as determined by this 805 application.

Re-determination date: Date the family will need to make appointment to complete new 805.

Section F: Other Services

This section will be used to document any referrals for other appropriate services need by family.

Write in others as appropriate. If no services were offered check NONE.

Provider sheet instructions:

COMPLETE THIS PAGE FOR EACH PROVIDER the family is using at the time of application or when the family is changing child care providers.

NOTE: Parent or provider will complete the unshaded aread / Voucher agent will complete shaded areas.

Section G: Provider Information

- 1. Name of provider
- 2. Telephone number where care is being provided.
- 3. Social Security Number or Employer Identification Number of provider.
- 4. Name of business or child care facility if other than name of provider.
- 5. Address of LOCATION OF CARE / mailing address.
- 6. City of location / mailing address
- 7. Zip code of location. If the provider is out-of-state, indicate this in this square.
- 8. County where care is located.
- 9. Type of care. From the code list in the box, place the number on the line that fits the description of the care facility / provider.
- 10. License or Registration Number / capacity number / number of sites for licensed or registered providers.
- 11. For Legally-Licensed Exempt home providers only: Date of birth / Age / Relationship to child, if any, of exempt provider.
- 12. This space can be used by the agency / provider to add additional information.

Section H: Child Care Needs / Expenses: Place family surname on line provided.

- . Name of each child in need of child care assistance.
- 2. Y / N for showing Proof of Special Needs: Documentation of Special Needs required (*Children with Special Health Care Services / First Steps / Special Education in Public School / Supplemental Security Income / Head Start enrolment for professionally diagnosed children with disabilities*) See manual for further clarification.
- 3. Place any additional costs associated with the special needs here (10% allowable over Market Rate).
- 4. Total hours needed per week based on service need.
- 5. Place the number of hours per day and the number of days per week of service need for each child.
- 6. Actual charge per service need established.
- 7. Indicate the county market rate in the column that fits the service need for each child.
- 8. Indicate any overcharge the family will be responsible for (6-7 = 8: Charges minus Market Rate).
- 9. Indicate the family co-pay per pay / week (see * at bottom of table of 805).
- 10. Actual child care subsidy using the formula at the ** bottom of the table on the 805.
- 11. Identify funding source # to be used for each child using the *** at bottom of table on the 805.

Signature of the provider and date is required.

Shaded box to be completed by Voucher Agent:

<u>Date To Meet Minimum Standards</u>: If your county has implemented Minimum Standards, indicate the date this provider has to complete them.

<u>Date For Provider Re-Certification</u>: Providers must be re-certified at least annualy. Recert date may be the license, registration, or minimum standards must be renewed.